



HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Incomplete forms will be returned

Please attach copies of the patient's medical history summary, lab and genetic test reports to the State.

****Please review our clinical criteria before submitting this form. ****

Patient Information

Recipient: _____ MA#: _____
Date of Birth: ____/____/____ Phone #: () ____ - ____ Body Weight: ____ kg

Treatment

- ☐ _____: Take _____ daily for _____ weeks
☐ _____: Take _____ daily for _____ weeks
☐ _____: Take _____ daily for _____ weeks

Adherence with prescribed therapy is a condition for payment of therapy for up to the allowed timeframe for each HCV genotype.

Has a treatment plan been developed and discussed with patient? ☐ No ☐ Yes

Does the patient have any history of medication non-adherence? ☐ No ☐ Yes; If yes, please explain below the details of non-adherence and how will it be addressed:

Diagnosis

☐ Acute Hep C ☐ Chronic Hep C ☐ Hepatocellular Carcinoma

☐ Liver transplant recipient: Genotype of pre-transplant liver: _____
Genotype of post-transplant liver: _____

☐ Other: _____

What is the patient's HCV genotype and subtype? _____

Has a liver biopsy been performed? ☐ No ☐ Yes; Test date : ____/____/____

Has a fibrosis test been performed: ☐ No

☐ Yes; Test used: _____; Test date : ____/____/____

Metavir Grade: _____; Metavir Stage: _____

What best describes this patient's liver disease? (Check all that apply):

☐ No cirrhosis ☐ Compensated cirrhosis ☐ Decompensated liver disease

****Please provide a copy of the results of the biopsy, genotype and any other fibrosis tests for this patient. ****

Hepatitis C Treatment History

Has this patient been treated for Hepatitis C in the past: ☐ Treatment Naive ☐ Treatment Experienced

If Treatment Experienced, what was the outcome of the previous treatments:

☐ Relapsed ☐ Partial Responder ☐ Non-Responder ☐ Toxicities

Genotype pre-DAA therapy: _____

Genotype post-DAA therapy: _____

Please indicate what prior regimen(s) the patient has been treated with:

HCV regimen	Treatment duration/ dates	Treatment Outcome
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial Responder <input type="checkbox"/> Non-Responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Relapsed <input type="checkbox"/> Partial Responder <input type="checkbox"/> Non-Responder <input type="checkbox"/> Toxicities <input type="checkbox"/> Other: _____

Laboratory Results

Baseline HCV RNA level (up to and including 90 days prior to treatment): _____ Date: _____/_____/_____

For all regimens please attach AST, ALT, total bilirubin and albumin

If a regimen is prescribed containing Sovaldi®, Harvoni®, Vosevi® or Epclusa®, please attach serum creatinine AND/OR eGFR

If a regimen is prescribed containing ribavirin, please attach hemoglobin, hematocrit and platelet count

Medical History

Is the patient co-infected with HIV? ☐ No ☐ Yes; If yes, state the patient's HIV viral load? _____
Date drawn: _____

Has patient had a solid organ transplant? ☐ No ☐ Yes; If yes, specify what type of transplant: _____
Date of transplant: _____/_____/_____

Substance Use History

Does the patient have an active diagnosis of a substance use disorder? ☐ Yes ☐ No

If Yes, is the patient actively engaged in treatment? ☐ Yes ☐ No;

If No, please indicate whether an adherence assessment has been done to assure successful treatment completion:

☐ Yes ☐ No, Please provide detail assessment plan: _____

If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the patient in other patient assistant drug programs to complete therapy? ☐ Yes ☐ No

I certify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's signature

Prescriber's Name

Date

Telephone# (_____) - _____ - _____ Fax# (_____) - _____ - _____

Practice Specialty: _____

Address: _____